Association for the Advancement of Blood & Biotherapies

Accredited Institutional (AI) Membership Application

----------Contact Information----------

Institution Name:

Street Address:

City/State/Zip Code:

Country:

Member Contact*:

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

* Contact is responsible for voting and invoicing.

Accreditation Information Contact*:

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

* Primary accreditation contact.

Accreditation Alternate Contact*

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

* Alternate accreditation contact.

Medical Director or Laboratory Director:

Name:

Title:

Phone Number:

Email Address:

Street Address:

City/State/Zip Code:

Country:

Membership Fees

Accredited Institutions are invoiced **annually** for the following: basic membership, volume, and accreditation fees. An AABB Lead Assessor fee will be included on the invoice for certain services. International institutions will incur an international travel fee. Contact accreditation@aabb.org for questions.

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Services Available for AABB Accreditation

----------Blood Banks/Transfusion Services - Blood Donor Centers----------

BLOOD DONOR CENTER

- ☐ Donor Center Activities - Community Blood Center
- ☐ Donor Center Activities - Hospital Blood Bank
- ☐ Donor Testing Only

TRANSFUSION SERVICES

- ☐ Transfusion Service

----------Cellular Therapy----------

HEMATOPOIETIC PROGENITOR CELLS (HPC)

- ☐ HPC Collection
- ☐ HPC Processing
- ☐ HPC Storage
- ☐ HPC Distribution

CORD BLOOD (CB)

- ☐ Cord Blood Collection
- ☐ Cord Blood Processing
- ☐ Cord Blood Storage
- ☐ Cord Blood Distribution

SOMATIC CELLS (SC)

- ☐ Somatic Cell Collection
- ☐ Somatic Cell Processing
- ☐ Somatic Cell Storage
- ☐ Somatic Cell Distribution

- ☐ **CLINICAL PROGRAM**

---Relationship Testing---

RELATIONSHIP TESTING

- ☐ Collection and Verification
- ☐ Testing

----------Specialty Services----------

- ☐ **PATIENT BLOOD MANAGEMENT**
  *International facilities only
- ☐ **PERIOPERATIVE SERVICES**
- ☐ **IMMUNOLOGY REFERENCE LAB**
- ☐ **MOLECULAR TESTING**

----------Out of Hospital/Pre-Hospital Transfusion Administration----------

- ☐ **SCHEDULED OUT OF HOSPITAL TRANSFUSION ADMINISTRATION**
- ☐ **EMERGENCY PRE-HOSPITAL TRANSFUSION ADMINISTRATION**

----------Other Services Provided by AABB----------

OTHER SERVICES

- ☐ CLIA PROVIDER
- ☐ HRSA PROVIDER

If accepted into AABB, on behalf of my institution, I pledge to foster and advance the principles and objectives which the Association represents, and to abide by its Code of Ethics and Bylaws (available upon request).

Date:

Printed Name:

Authorized Signature: